		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037317

Facility Name: Lexington of Elmhurst

Address: 420 W. Butterfield Road (Number) Elmhurst (City) 60126 (Zip Code)

County: DuPage

Telephone Number: (630) 832-2300 **Fax #** (630) 832-7043

IDPA ID Number: 363682838001

Date of Initial License for Current Owners: 11/12/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 **Fax #** (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,597	5,641	8,979	31,217	8
9	SNF/PED					9
10	ICF	10,654	8,792	101	19,547	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,251	14,433	9,080	50,764	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.72%

D. How many bed-hold days during this year were paid by Public Aid?
74 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/12/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 47 and days of care provided 7,978

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	287,842	30,514	11,929	330,285		330,285		330,285			1
2	Food Purchase		211,953		211,953		211,953	(9,438)	202,515			2
3	Housekeeping	194,867	30,550		225,417		225,417	261	225,678			3
4	Laundry	47,839	17,970		65,809		65,809	(2,323)	63,486			4
5	Heat and Other Utilities			189,647	189,647		189,647	2,619	192,266			5
6	Maintenance	61,284		93,583	154,867		154,867	1,666	156,533			6
7	Other (specify):*											7
8	**TOTAL General Services**	591,832	290,987	295,159	1,177,978		1,177,978	(7,215)	1,170,763			8
	B. Health Care and Programs											
9	Medical Director			19,250	19,250		19,250		19,250			9
10	Nursing and Medical Records	2,222,359	136,394	32,307	2,391,060		2,391,060		2,391,060			10
10a	Therapy			757,583	757,583		757,583		757,583			10a
11	Activities	163,137	13,142	3,458	179,737		179,737		179,737			11
12	Social Services	72,946		2,788	75,734		75,734		75,734			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,458,442	149,536	815,386	3,423,364		3,423,364		3,423,364			16
	C. General Administration											
17	Administrative	169,598		354,280	523,878		523,878	(354,280)	169,598			17
18	Directors Fees											18
19	Professional Services			52,778	52,778		52,778	7,456	60,234			19
20	Dues, Fees, Subscriptions & Promotions			22,306	22,306		22,306	(426)	21,880			20
21	Clerical & General Office Expenses	343,367	35,078	21,716	400,161		400,161	16,149	416,310			21
22	Employee Benefits & Payroll Taxes			488,119	488,119		488,119	55,091	543,210			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,986	3,986		3,986	1,988	5,974			24
25	Other Admin. Staff Transportation							6,564	6,564			25
26	Insurance-Prop.Liab.Malpractice			134,774	134,774		134,774	2,571	137,345			26
27	Other (specify):*											27
28	**TOTAL General Administration**	512,965	35,078	1,077,959	1,626,002		1,626,002	(264,887)	1,361,115			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,563,239	475,601	2,188,504	6,227,344		6,227,344	(272,102)	5,955,242			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Lexington of Elmhurst #0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			46,574	46,574		46,574	138,868	185,442			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,904	6,904		6,904	253,788	260,692			32
33	Real Estate Taxes							74,785	74,785			33
34	Rent-Facility & Grounds			853,497	853,497		853,497	(853,497)				34
35	Rent-Equipment & Vehicles			3,639	3,639		3,639	2,850	6,489			35
36	Other (specify):*											36
37	**TOTAL Ownership**			910,614	910,614		910,614	(383,206)	527,408			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		205,469	350	205,819		205,819		205,819			39
40	Barber and Beauty Shops			32,055	32,055		32,055		32,055			40
41	Coffee and Gift Shops			1,114	1,114		1,114		1,114			41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* Nonallowable Costs			70,271	70,271		70,271	(70,271)				43
44	**TOTAL Special Cost Centers**		205,469	185,915	391,384		391,384	(70,271)	321,113			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,563,239	681,070	3,285,033	7,529,342		7,529,342	(725,579)	6,803,763			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(293)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(2,323)	4		8
9	Non-Straightline Depreciation	1,692	30		9
10	Interest and Other Investment Income	(255)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,208)	43		13
14	Non-Care Related Interest	(512)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,483)	43		17
18	Fines and Penalties	(437)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,425)	43		24
25	Fund Raising, Advertising and Promotional	(11,504)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,636)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule A	(10,161)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,545)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(652,034)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (652,034)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (725,579)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/03 - 12/31/03

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Disallow radiology	(5,357)	43
Disallow laboratory	(3,221)	43
Nonallowable collections	(129)	19
Miscellaneous income offset	(168)	21
Nonallowable Chamber of Commerce dues	(1,000)	19
Disallow out of period legal fees	(286)	19
Total	(10,161)	

See Accountants' Compilation Report

Lexington of Elmhurst

ID# 0037317

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(293)	0	0	0	0	0	0	0	0	0	0	(293)	2
3	Housekeeping	0	0	261	0	0	0	0	0	0	0	0	261	3
4	Laundry	(2,323)	0	0	0	0	0	0	0	0	0	0	(2,323)	4
5	Heat and Other Utilities	0	0	2,619	0	0	0	0	0	0	0	0	2,619	5
6	Maintenance	0	0	1,666	0	0	0	0	0	0	0	0	1,666	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,616)	0	4,546	0	0	0	0	0	0	0	0	1,930	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(354,280)	0	0	0	0	0	0	0	(354,280)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	104	7,767	0	0	0	0	0	0	0	0	7,871	19
20	Fees, Subscriptions & Promotions	0	0	574	0	0	0	0	0	0	0	0	574	20
21	Clerical & General Office Expenses	0	85	16,232	0	0	0	0	0	0	0	0	16,317	21
22	Employee Benefits & Payroll Taxes	0	0	45,946	0	0	0	0	0	0	0	0	45,946	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,988	0	0	0	0	0	0	0	0	1,988	24
25	Other Admin. Staff Transportation	0	0	0	6,564	0	0	0	0	0	0	0	6,564	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,571	0	0	0	0	0	0	0	2,571	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	189	72,507	(345,145)	0	0	0	0	0	0	0	(272,449)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,616)	189	77,053	(345,145)	0	0	0	0	0	0	0	(270,519)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Elmhurst # 0037317 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,692	115,753	0	21,423	0	0	0	0	0	0	0	138,868	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(767)	254,316	0	239	0	0	0	0	0	0	0	253,788	32
33	Real Estate Taxes	0	73,497	0	1,288	0	0	0	0	0	0	0	74,785	33
34	Rent-Facility & Grounds	0	(853,497)	0	0	0	0	0	0	0	0	0	(853,497)	34
35	Rent-Equipment & Vehicles	0	0	0	2,850	0	0	0	0	0	0	0	2,850	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	925	(409,931)	0	25,800	0	0	0	0	0	0	0	(383,206)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(61,693)	0	0	0	0	0	0	0	0	0	0	(61,693)	43
44	**TOTAL Special Cost Centers**	(61,693)	0	0	0	0	0	0	0	0	0	0	(61,693)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(63,384)	(409,742)	77,053	(319,345)	0	0	0	0	0	0	0	(715,418)	45

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of Elmhurst		
See attached Schedule B		See attached Schedule B		II Ltd. Ptsp.	Elmhurst	Real estate ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 853,497	Sambell of Elmhurst II Limited Partnership	**	$	$ (853,497)	1
2	V	19	Professional fees		Sambell of Elmhurst II Limited Partnership	**	104	104	2
3	V	21	Bank charges		Sambell of Elmhurst II Limited Partnership	**	85	85	3
4	V	30	Depreciation		Sambell of Elmhurst II Limited Partnership	**	115,753	115,753	4
5	V	32	Interest expense		Sambell of Elmhurst II Limited Partnership	**	251,887	251,887	5
6	V	32	Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	2,429	2,429	6
7	V	33	Property taxes		Sambell of Elmhurst II Limited Partnership	**	73,497	73,497	7
8	V								8
9	V								9
10	V				** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100%				10
11	V				of Sambell of Elmhurst II Limited Partnership				11
12	V								12
13	V								13
14	Total			$ 853,497			$ 443,755	$ * (409,742)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/03 - 12/31/03

Schedule B

VII. Related Parties
Owners

Name	Ownership %
James Samatas Discretionary Trust	16.66%
John Samatas Discretionary Trust	16.67%
Cynthia Thiem Discretionary Trust	16.67%
David S. Bell Revocable Trust	12.50%
Jeffrey J. Bell Revocable Trust	12.50%
Lawrence W. Bell Revocable Trust	12.50%
David S. Bell 2001 Trust	4.16%
Jeffrey J. Bell 2001 Trust	4.17%
Lawrence W. Bell 2001 Trust	4.17%

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 261	$ 261	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	2,572	2,572	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	47	47	17
18	V	6	Repairs & maintenance		Royal Management Corp.	**	1,618	1,618	18
19	V	6	Scavenger & exterminating		Royal Management Corp.	**	48	48	19
20	V	19	Computer consultant & supplies		Royal Management Corp.	**	5,852	5,852	20
21	V	19	Professional fees		Royal Management Corp.	**	1,915	1,915	21
22	V	20	Advertising - help wanted		Royal Management Corp.	**	130	130	22
23	V	20	Dues & subscriptions		Royal Management Corp.	**	444	444	23
24	V	21	Bank charges		Royal Management Corp.	**	2,250	2,250	24
25	V	21	Office supplies & printing		Royal Management Corp.	**	5,139	5,139	25
26	V	21	Postage		Royal Management Corp.	**	2,312	2,312	26
27	V	21	Telephone		Royal Management Corp.	**	6,531	6,531	27
28	V	22	FICA		Royal Management Corp.	**	20,752	20,752	28
29	V	22	FUTA		Royal Management Corp.	**	373	373	29
30	V	22	SUTA		Royal Management Corp.	**	645	645	30
31	V	22	Insurance - W/C		Royal Management Corp.	**	393	393	31
32	V	22	Insurance - hospitalization		Royal Management Corp.	**	20,509	20,509	32
33	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	3,274	3,274	33
34	V	24	Travel & seminar		Royal Management Corp.	**	1,988	1,988	34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 77,053	$ * 77,053	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 6,564	$ 6,564	15
16	V	26	Insurance general		Royal Management Corp.	**	2,571	2,571	16
17	V	30	Depreciation - vehicles		Royal Management Corp.	**	2,277	2,277	17
18	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	5,324	5,324	18
19	V	30	Depreciation - equipment		Royal Management Corp.	**	13,822	13,822	19
20	V	32	Interest		Royal Management Corp.	**	239	239	20
21	V	33	Property taxes		Royal Management Corp.	**	1,288	1,288	21
22	V	35	Equipment rental		Royal Management Corp.	**	2,850	2,850	22
23	V	17	Management Fees	354,280	Royal Management Corp.	**		(354,280)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 354,280			$ 34,935	$ * (319,345)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	16.66%	See Schedule C	4	8%	Salary	$ 23,751	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	16.67%	See Schedule C	2	4%	Salary	14,844	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	16.67%	See Schedule C	1	3%	Salary	11,875	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4%	Salary	3,563	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	3	6%	Salary	9,055	L 17, C 1	5
6											6
7											7
8											8
9						All individuals work in excess of 40 hours per week.						9
10											10
11											11
12											12
13								TOTAL	$ 63,088		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/03 - 12/31/03

Schedule C

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	17,021	27,234	13,617	4,085	10,383	72,340
Lexington Health Care Center of Chicago Ridge, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of LaGrange, Inc.	10,787	17,259	8,629	2,589	6,580	45,844
Lexington Health Care Center of Lake Zurich, Inc.	20,089	32,143	16,071	4,821	12,254	85,378
Lexington Health Care Center of Lombard, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Orland Park, Inc.	26,721	42,748	21,376	6,413	16,298	113,556
Lexington Health Care Center of Schaumburg, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Streamwood, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Wheeling, Inc.	21,870	34,993	17,496	5,249	13,342	92,950
Total	185,156	296,249	148,125	44,437	112,945	786,912

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	$ 3,521	$	54,750	$ 261	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	34,652		54,750	2,572	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	635		54,750	47	3
4	6	Repairs & maintenance	Bed Days	737,665	10	21,802		54,750	1,618	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	648		54,750	48	5
6	19	Computer consultant & supplies	Bed Days	737,665	10	78,852		54,750	5,852	6
7	19	Professional fees	Bed Days	737,665	10	25,806		54,750	1,915	7
8	20	Advertising - help wanted	Bed Days	737,665	10	1,748		54,750	130	8
9	20	Dues & subscriptions	Bed Days	737,665	10	5,976		54,750	444	9
10	21	Bank charges	Bed Days	737,665	10	30,319		54,750	2,250	10
11	21	Office supplies & printing	Bed Days	737,665	10	69,243		54,750	5,139	11
12	21	Postage	Bed Days	737,665	10	31,145		54,750	2,312	12
13	21	Telephone	Bed Days	737,665	10	87,995		54,750	6,531	13
14	22	FICA	Bed Days	737,665	10	279,595		54,750	20,752	14
15	22	FUTA	Bed Days	737,665	10	5,021		54,750	373	15
16	22	SUTA	Bed Days	737,665	10	8,695		54,750	645	16
17	22	Insurance - W/C	Bed Days	737,665	10	5,294		54,750	393	17
18	22	Insurance - hospitalization	Bed Days	737,665	10	276,319		54,750	20,509	18
19	22	401(k) and other emp. benefits	Bed Days	737,665	10	44,113		54,750	3,274	19
20	24	Travel & seminar	Bed Days	737,665	10	26,781		54,750	1,988	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,038,160	$		$ 77,053	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	$ 88,444	$	54,750	$ 6,564	1
2	26	Insurance - general	Bed Days	737,665	10	34,634		54,750	2,571	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	30,679		54,750	2,277	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	71,727		54,750	5,324	4
5	30	Depreciation - equipment	Bed Days	737,665	10	186,226		54,750	13,822	5
6	32	Interest	Bed Days	737,665	10	3,219		54,750	239	6
7	33	Property taxes	Bed Days	737,665	10	17,360		54,750	1,288	7
8	35	Equipment rental	Bed Days	737,665	10	38,401		54,750	2,850	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 470,690	$		$ 34,935	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial Services						$	$			$	1
2	II, L.L.C.	X		Mortgage	$32,361.00	12/29/98	4,256,000	3,668,719	01/2008	0.0675	251,887	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank, N.A.		X	Line of Credit	Varies	04/06/02	500,000		4/4/04	Prime	6,392	6
7	Shareholder Loan	X		Working Capital	Varies	04/30/03	100,000		6/23/03	0.0425	512	7
8												8
9	TOTAL Facility Related				$32,361.00		$ 4,856,000	$ 3,668,719			$ 258,791	9
	B. Non-Facility Related*											
10								Nonallowable shareholder interest			(512)	10
11								Amortization of loan costs			2,429	11
12								Interest income offset			(255)	12
13								Allocated from management company			239	13
14	TOTAL Non-Facility Related						$	$			$ 1,901	14
15	TOTALS (line 9+line14)						$ 4,856,000	$ 3,668,719			$ 260,692	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 69,000	1
	Allocated from Management Company	1,288	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 69,897	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,185	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 72,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 74,785	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	62,599	8
1999	63,573	9
2000	62,228	10
2001	65,080	11
2002	69,897	12

2003 assessment:	1,585,660
Equalization factor:	1.0396
Tax Rate:	0.04408
Est. '03 taxes payable '04:	72,664
Use:	72,600

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Elmhurst COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0037317

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-14-317-008	Land and building	$ 69,897.48	$ 69,897.48
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-019	Land and building	$ 212,239.00	$ 1,288.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 282,136.48	$ 71,185.48

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	55,000	1991	$ 1,277,670	1
2	Allocated from management company			11,841	2
3	TOTALS	55,000		$ 1,289,511	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	138		1991	1991	$ 4,110,586	$	35	$ 117,445	$ 117,445	$ 1,423,807	4
5	10		1995	1995	73,302	2,095	35	2,095		18,131	5
6	2		2001	2001							6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1992	693	20	35	20		223	9
10	Land Improvement			1995	7,500	500	15	500		4,167	10
11	Fan Coil Units			1996	4,903	140	35	140		1,051	11
12	Patio			1996	2,322	155	15	155		1,161	12
13	Basement rehab			1997	17,151	1,715	10	1,715		11,005	13
14	Baseboards			1997	3,129	313	10	313		1,956	14
15	Wiring			1998	3,090	309	10	309		1,700	15
16	Lobby Tile			1999	19,354	1,935	10	1,935		9,515	16
17	Patio			1999	4,196	280	15	280		1,119	17
18	Automatic Door			2000	1,300	130	10	130		455	18
19	Wallpaper			2000	6,853	685	10	685		2,398	19
20	Patio			2000	1,242	83	15	83		290	20
21	Storage closet for HVAC			2000	3,745	250	15	250		874	21
22	Fire pump system			2001	4,141	414	10	414		1,035	22
23	Door releases			2001	4,420	442	10	442		1,105	23
24	Infrared curtains for elevators			2001	3,000	300	10	300		750	24
25	Parking lot			2002	2,532	253	10	253		506	25
26	Kitchen tile and plumbing			2002	9,661	966	10	966		1,630	26
27	Elevator upgrade			2002	2,595	519	5	519		735	27
28	Facility Rehab-Painting/wallpaper/carpeting			2003	175,252	16,065	10	16,065		16,065	28
29	Facility Rehab-Floor tile/room upgrade			2003	38,140	1,748	20	1,748		1,748	29
30	Facility Rehab-Carpeting			2003	7,860	655	10	655		655	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Leasehold improvements - management company	1995	$ 7,505	$	35	$ 222	$ 222	$ 1,823	37
38	Leasehold improvements - management company	1996	6,108		35	181	181	1,309	38
39	Leasehold improvements - management company	1989	211		31	6	6	106	39
40	HVAC - management company	1998	158		35	5	5	27	40
41	Offices - management company	1999	399		35	12	12	51	41
42	Land improvements - management company	2002	18,663		15	553	553	2,385	42
43	Building - management company	2002	145,197		40	4,302	4,302	6,957	43
44	HVAC, electrical, security system - management company	2003	1,439		30	43	43	37	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,686,647	$ 29,972		$ 152,741	$ 122,769	$ 1,514,776	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 124,381	$ 15,741	$ 15,741	$	5-10 years	$ 77,579	71
72	Current Year Purchases	31,747	861	861		3-10 years	861	72
73	Fully Depreciated Assets	268,783					268,783	73
74	Allocated from Management Company	132,903		13,822	13,822		44,046	74
75	TOTALS	$ 557,814	$ 16,602	$ 30,424	$ 13,822		$ 391,269	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Management Company			22,208		2,277	2,277		17,731	79
80	TOTALS			$ 22,208	$	$ 2,277	$ 2,277		$ 17,731	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,556,180	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 46,574	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 185,442	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 138,868	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,923,776	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 6,489 Description: Copier - $3,639; Allocated from Management Company - $2,850
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Facility does not hire non-trained aides.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	4,025	$ 249,393	$	4,025	$ 249,393	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		475	32,677		475	32,677	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,953	475,513		8,953	475,513	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				205,469		205,469	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Ambulance	L39, C3				350			350	13
14	TOTAL			$	13,453	$ 757,933	$ 205,469	13,453	$ 963,402	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 503,733	$ 506,164	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 441,532)	1,562,997	1,562,997	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,015	42,015	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	53,347	53,347	8
9	Other(specify): Escrow		31,622	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,162,092	$ 2,196,145	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,628	5,628	12
13	Land		1,289,511	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	396,381	576,061	15
16	Equipment, at Historical Cost	153,917	580,022	16
17	Accumulated Depreciation (book methods)	(158,400)	(1,923,776)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized loan costs		36,443	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 397,526	$ 4,674,475	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,559,618	$ 6,870,620	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 360,623	$ 360,623	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,640	169,640	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,040	4,040	31
32	Accrued Real Estate Taxes(Sch.IX-B)		72,600	32
33	Accrued Interest Payable		20,637	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	125,884	72,742	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 660,187	$ 700,282	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,668,719	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,668,719	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 660,187	$ 4,369,001	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,899,431	$ 2,501,619	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,559,618	$ 6,870,620	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/03 - 12/31/03

Schedule E

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued rent	53,142	
Accrued 401 (k) contribution	11,716	11,716
Due to related party	28,697	28,697
Other accrued expenses	32,329	32,329
Total line 36	125,884	72,742

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Investment in Lexington Financial Services, L.L.C. II	316
Miscellaneous income	168
Total line 28	484

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,516,781	1
2	Restatements (describe):		2
3			3
4			4
5	Rounding	(3)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,516,778	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,736,810	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,354,157)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 382,653	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,899,431	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,256,508	1
2	Discounts and Allowances for all Levels	(639,116)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,617,392	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,275,373	6
7	Oxygen	(7)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,275,366	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	774	12
13	Barber and Beauty Care	38,126	13
14	Non-Patient Meals	293	14
15	Telephone, Television and Radio	49	15
16	Rental of Facility Space		16
17	Sale of Drugs	222,637	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,717	19
20	Radiology and X-Ray	6,764	20
21	Other Medical Services	89,972	21
22	Laundry	2,323	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 372,655	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	255	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 255	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	484	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 484	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,266,152	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,177,978	31
32	Health Care	3,423,364	32
33	General Administration	1,626,002	33
	B. Capital Expense		
34	Ownership	910,614	34
	C. Ancillary Expense		
35	Special Cost Centers	309,259	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,529,342	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,736,810	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,736,810	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity files a cash basis tax return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,112	2,357	$ 90,992	$ 38.61	1
2	Assistant Director of Nursing	3,637	3,741	108,220	28.93	2
3	Registered Nurses	30,958	34,146	882,733	25.85	3
4	Licensed Practical Nurses	9,047	10,244	220,186	21.49	4
5	Nurse Aides & Orderlies	72,949	77,712	847,857	10.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,059	5,698	72,371	12.70	8
9	Activity Director	2,094	2,175	32,661	15.02	9
10	Activity Assistants	12,933	13,902	130,476	9.39	10
11	Social Service Workers	4,214	4,367	72,946	16.70	11
12	Dietician	2,068	2,284	33,022	14.46	12
13	Food Service Supervisor	1,923	2,296	35,791	15.59	13
14	Head Cook	2,044	2,164	21,739	10.05	14
15	Cook Helpers/Assistants	13,201	13,994	115,214	8.23	15
16	Dishwashers	11,687	12,497	82,076	6.57	16
17	Maintenance Workers	3,306	3,823	61,284	16.03	17
18	Housekeepers	28,120	29,713	194,867	6.56	18
19	Laundry	7,164	7,719	47,839	6.20	19
20	Administrator	2,011	2,303	106,510	46.25	20
21	Assistant Administrator					21
22	Other Administrative	479	482	63,088	130.89	22
23	Office Manager					23
24	Clerical	14,786	16,983	343,367	20.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	229,792	248,600	$ 3,563,239 *	$ 14.33	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	220	$ 11,929	L 1, C 3	35
36	Medical Director	14	19,250	L 9, C 3	36
37	Medical Records Consultant	18	900	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	3,458	L 11, C 3	44
45	Social Service Consultant	61	2,788	L 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	337	$ 39,525		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Murphy	Administrator	0%	$ 106,510
John Samatas	Admin/Plant Ops	16.67	14,844
James Samatas	Administrative	16.66	23,751
Cynthia Thiem	Administrative	16.67	11,875
George Samatas	Administrative	0%	3,563
Jason Samatas	Administrative	0%	9,055
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,598

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 354,280
TOTAL (agree to Schedule V, line 17, col. 3)	$ 354,280
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ING	401(k) administration	$ 345
Altschuler, Melvoin & Glasser LLP	Accounting	14,664
American Express Tax & Bus Srv	Accounting	4,813
Freedman, Anselmo & Lindberg	Collections	129
Personnel Planners	U/C Consulting	1,215
James Samatas	Legal	50
Katten Muchin Zavis Rosenman	Legal	3,244
Carol Jeschke	Staffing Consultant	2,837
See attached Schedule F		25,481
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 52,778

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,262
Unemployment Compensation Insurance	40,298
FICA Taxes	258,997
Employee Health Insurance	159,123
Employee Meals	9,145
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	13,587
Other Employee Benefits	7,798
TOTAL (agree to Schedule V, line 22, col.8)	$ 543,210

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,872
Health Care Worker Background Check	
(Indicate # of checks performed)	
Miscellaneous dues & subscriptions	234
Miscellaneous licenses and permits	1,200
Allocated from Management Company	574
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,880

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,986
Allocated from Management Company	1,988
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,974

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/03 - 12/31/03

Schedule F

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Harris Kessler & Goldstein	Legal	1,039
Sachnoff & Weaver	Legal	4,355
Gilson, Labus & Silverman	Legal	52
Nyemaster, Goode, Voigts, West, Hansell & O'Brien	Legal	850
Serpico & Novelle, Ltd.	Legal	12,887
KraKau Business Computer	Computer Consulting	1,125
Answers on Demand	Computer Consulting	2,652
eHealth Solutions	Computer Consulting	1,080
Gigatrend	Computer Consulting	195
Information Controls, Inc.	Computer Consulting	868
Administar Federal	Computer Consulting	378
Total, Other Professional Services		25,481
Total, Agrees to Schedule V, Line 19, Column 3		52,778
Allocated from management co.		
American Express Tax & Business Services	Accounting	417
Gilson, Labus and Silverman	Accounting	38
James Samatas	Legal	52
Katten, Muchin, Zavis and Rosenman	Legal	49
Sachnoff and Weaver	Legal	379
ING / Pension Administrators	401 (k) Administration	512
Personnel Planners	U/C Consulting	18
Various	Consulting	451
Various	Computer Consulting	5,852
Allocated from building partnership		
James Samatas	Filing and recording fees	103
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(129)
Katten, Muchin, Zavis and Rosenman	Out of period legal fees	(286)
Total, Agrees to Schedule V, Line 19, Column 8		60,234

See accountants' compilation report.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4							N/A						
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **40,228** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **9,145** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **293**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lexington of Elmhurst 12:22 PM ######**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	Explanation
Adjustment Detail	-725,579	equal to	-725,579	0	O.K.	
Interest Expense	260,692	equal to	260,692	0	O.K.	
Real Estate Tax Expenses	74,785	equal to	74,785	0	O.K.	
Amortization exp. Pre-opening & org	N/A	equal to	0	#VALUE!	#VALUE!	
Ownership Costs-Depreciation	185,442	equal to	185,442	0	O.K.	
Rental Costs A	0	equal to	0	0	O.K.	
Rental Costs B	6,489	equal to	6,489	0	O.K.	
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	
Special Serv.- Staff Wages		equal to		0	O.K.	
Therapy Services	757,583	equal to	757,583	0	O.K.	
Special Serv.- Supplies	205,469	equal to	#VALUE!	#VALUE!	#VALUE!	
Income Stat. General Serv.	1,177,978	equal to	1,177,978	0	O.K.	
Income Stat. Health Care	3,423,364	equal to	3,423,364	0	O.K.	
Income Stat. Admininstatior	1,626,002	equal to	1,626,002	0	O.K.	
Income Stat. Ownership	910,614	equal to	910,614	0	O.K.	
Income Stat. Special Cost Ctr	309,259	equal to	309,259	0	O.K.	
Income Stat. Prov. Partic.	82,125	equal to	82,125	0	O.K.	
Staff- Nursing	2,222,359	equal to	2,222,359	0	O.K.	
Staff- Nurse aide Training	0	< or = to		0	O.K.	
Staff-Licensed Therapist	0	equal to		0	O.K.	
Staff- Activities	163,137	equal to	163,137	0	O.K.	
Staff- Social Serv. Workers	72,946	equal to	72,946	0	O.K.	
Staff- Dietary	287,842	equal to	287,842	0	O.K.	
Staff- Maintenance	61,284	equal to	61,284	0	O.K.	
Staff- Housekeeping	194,867	equal to	194,867	0	O.K.	
Staff- Laundry	47,839	equal to	47,839	0	O.K.	
Staff- Administrative	169,598	equal to	169,598	0	O.K.	
Staff- Clerical	343,367	equal to	343,367	0	O.K.	
Staff- Medical Director	0	equal to		0	O.K.	
Total Salaries And Wages	3,563,239	equal to	3,563,239	0	O.K.	
Dietary Consultant	11,929	< or = to	11,929	0	O.K.	
Medical Director	19,250	< or = to	19,250	0	O.K.	
Consultants & contractors	2,100	< or = to	32,307	-30,207	O.K.	ok, $30,207 of other included
Activity Consultant	3,458	< or = to	3,458	0	O.K.	
Social Service Consultant	2,788	< or = to	2,788	0	O.K.	
Supp. Sched.- Admin. Salar.	169,598	equal to	169,598	0	O.K.	
Supp. Sched.- Admin. Other	354,280	equal to	354,280	0	O.K.	
Supp. Sched.- Prof. Serv.	52,778	equal to	52,778	0	O.K.	
Professional Fees - p.3 column 8	60,234	equal to	60,234	0	alrighty now	
Supp. Sched.- Benefit/Taxes	543,210	equal to	543,210	0	O.K.	
Supp. Sched.- Sched of dues..	21,880	equal to	21,880	0	O.K.	
Supp. Sched.- Sched. of trav	5,974	equal to	5,974	0	O.K.	
Gen. Info - Particip. Fees	82,125	equal to	82,125	0	O.K.	
Gen. Info - Employee Meals	9,145	< or = to	55,091	-45,946	O.K.	ok
Gen. Info - Employee Meals	9,145	equal to	9,145	0	O.K.	
Nurse aide training	0	equal to		0	O.K.	
Days of medicare provided	7,978	equal to	8,979	-1,001	FAILED	Ok, 7,978 of medicare days
Adjustment for related org. costs	-652,034	equal to	-652,034	0	O.K.	
Total loan balance	3,668,719	equal to	3,668,719	0	O.K.	
Real estate tax accrual	72,600	equal to	72,600	0	O.K.	
Land	1,289,511	equal to	1,289,511	0	O.K.	
Building cost	4,686,647	equal to	4,686,647	0	O.K.	
Equipment and vehicle cost	580,022	equal to	580,022	0	O.K.	
Accumulated depr.	1,923,776	equal to	1,923,776	0	O.K.	
End of year equity	1,899,431	equal to	1,899,431	0	O.K.	
Net income (loss)	1,736,810	equal to	1,736,810	0	O.K.	
Unamortized deferred maint. cost	0	equal to		0	O.K.	
Balance Sheet	2,559,618	equal to	2,559,618	0	O.K.	

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK**						
	TO THE COST REPORT!!		11/4/2005		12:22:01 PM		
HSA Number	?	Name	**Lexington of Elmhurst**				
Cost report period	From:	01/01/03	To:	12/31/03	Base Number		336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N					
Licensed bed days:	54,750	Occupancy:	50,764	Pct. of occupancy:		92.72%	
Illinois Public Aid Support Rate		$					
Genl Services Salary/Wage:	591,832	Col 1, Line 8 ---Audit Adj:					
Genl Admin Salary/Wage	512,965	Col 1, Line 28 ---Audit Adj					
Total Salary Wage	3,563,239	Col 1, Line 44 ---Audit Adj					
Employee Benefits	543,210	Col 8, Line 22 ---Audit Adj					
Total General Services:	1,170,763	Col 8, Line 8 ---Audit Adj:					
Total General Admin	1,361,115	Col 8, Line 28 ---Audit Adj					

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amou out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amour by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$591,832
Divided by Total Wages (Column 1, Line 44	$3,563,239
General service wages as percent of total wages	16.6094%
Employee Benefits (Column 10, Line 22	$543,210
Allocation of Employee Benefits to General Services Costs	$90,224
Plus Total General Services (Column 10, Line 8	$1,170,763
New Total General Services Cost	$1,260,987

B. General Administration

1 Determine the proportion of General Administratio wages to total wages.

2 Multiply the total lump sum fringe amount by th proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your tota General Administration expenses

4 Subtract the total lump sum fringe amount from you General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$512,965
Divided by Total Wages (Column 1, Line 45	$3,563,239
General administration wages as a percent of total wages	14.3960%
Employee Benefits (Column 10, Line 22	$543,210
Allocation of Emplayee Benefits to General Admin. Cost	$78,201
Plus Total General Administration (Column 10, Line 2	$1,361,115
Minus Total Fringe (Column 10, Line 2:	$543,210
New Total General Administration Cos	$896,106

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflatior fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To selec the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select th inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multiplier

Refer to Table I, inflation Multipliers, and find th multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$1,260,987	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$1,260,987

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$896,106	
General Administration Multiplier (Step II-B	1	
Updated General Services Cost		$896,106
3 Total Updated Support Costs (1 + 2		$2,157,093

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $42.45

A. If the occupancy (Cost Report, Page 2, Schedule III-C) i equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patien days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$2,157,093
Total Patient Days (Cost Report	50,764
Support Costs per Dien	$42.49

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patier days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	54,750
Multiplied by	0.93
	50,918
Minus total Patient Day	50,764
	154
One-third of difference	51
Plus Total Patient Day	50,764
Adjusted Occupancy	50,815
Total Support Costs (Step II, C, 3, above	$2,157,093
Divided by Adjusted Occupany	50815
Support Costs Per Dien	$42.45

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to c greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to o greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$42.45
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Plus Support Costs Per Dier	$42.45
Support Rate if costs are between 35th and 75th percentile	#N/A

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal tc 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$42.45
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Compare one-half the difference to the profit ceiling for your HSA in Table II and	#N/A
Enter the Lower of the Two Amounts	#N/A
Plus Support Costs Per Dier	$42.45
Support Rate if support costs less than 35th percentile	#N/A

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abc **#N/A**

75th Percentile is	#N/A
35th Percentile is	#N/A

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/4/2005 12:22:01 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Lexington of Elmhurst** ID: **0037317**

HSA No.: ? Own or Rent? (O or R): ____ Own or Rent Beginning: ____

IF RENTED, have facilities been continously rented
from an unrelated party since prior to January 1, 1978 (Y or N): N
or since the first day of operation for buildings
constructed since January 1, 1978?

Cost Report Pd:		Licensed Beds:	150	Total Patient Days	50,764
Begin	**01/01/03**	Licensed Bed Days:	54,750	% Occupied	92.72%
End	**12/31/03**			Capital Days	50,918

1989 Property Tax COST: ____ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ____ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ____ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1992
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	4686647
2. Total licensed beds from cost report Page 2, Line 7, column 3	150
3. Line 1 divided by Line 2	$31,244
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	50,918
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	50,764
2. Total Licensed Bed Days * .93	50918
3. Capital Days (higher of Line 1 or Line 2)	50,918

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	91	4110586	374063326	12
2	2	95	73302	6963690	12
3	3	101	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	92	693	63756	12
7	7	95	7500	712500	12
8	8	96	4903	470688	12
9	9	96	2322	222912	12
10	10	97	17151	1663647	12
11	11	97	3129	303513	12
12	12	98	3090	302820	12
13	13	99	19354	1916046	12
14	14	99	4196	415404	12
15	15	100	1300	130000	12
16	16	100	6853	685300	12
17	17	100	1242	124200	12
18	18	100	3745	374500	12
19	19	101	4141	418241	12
20	20	101	4420	446420	12
21	21	101	3000	303000	12
22	22	102	2532	258264	12
23	23	102	9661	985422	12
24	24	102	2595	264690	12
25	25	103	175252	18050956	12
26	26	103	38140	3928420	12
27	27	103	7860	809580	12
28	28	0	0	0	12
29	29	0	0	0	12
30	30	0	0	0	12
31	31	0	0	0	12
32	32	0	0	0	12
33	33	0	0	0	12
34	34	95	7505	712975	12A
35	35	96	6108	586368	12A
36	36	89	211	18779	12A
37	37	98	158	15484	12A
38	38	99	399	39501	12A
39	39	102	18663	1903626	12A
40	40	102	145197	14810094	12A
41	41	103	1439	148217	12A
42	42	0	0	0	12A
43	43	0	0	0	12A
44	44	0	0	0	12A
45	45	0	0	0	12A
46	46	0	0	0	12A
47	47	0	0	0	12A
48	48	0	0	0	12A
49	49	0	0	0	12A
50	50	0	0	0	12A
51	51	0	0	0	12A
52	52	0	0	0	12A
53	53	0	0	0	12A
54	54	0	0	0	12A
55	55	0	0	0	12A
56	56	0	0	0	12A
57	57	0	0	0	12A
58	58	0	0	0	12A
59	59	0	0	0	12A
60	60	0	0	0	12A
61	61	0	0	0	12A
62	62	0	0	0	12A
63	63	0	0	0	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	0	0	0	12B
69	69	0	0	0	12B
70	70	0	0	0	12B
71	71	0	0	0	12B
72	72	0	0	0	12B
73	73	0	0	0	12B
74	74	0	0	0	12B
75	75	0	0	0	12B
76	76	0	0	0	12B
77	77	0	0	0	12B
78	78	0	0	0	12B
79	79	0	0	0	12B
80	80	0	0	0	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

432112339 4686647 92.20074373

Base Year = 1992

TABLE 1 error

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	287,842	30,514	11,929	330,285	0	330,285	0	330,285
2. Food Purchase	0	211,953	0	211,953	0	211,953	-9,438	202,515
3. Housekeeping	194,867	30,550	0	225,417	0	225,417	261	225,678
4. Laundry	47,839	17,970	0	65,809	0	65,809	-2,323	63,486
5. Heat and Other Utilities	0	0	189,647	189,647	0	189,647	2,619	192,266
6. Maintenance	61,284	0	93,583	154,867	0	154,867	1,666	156,533
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	591,832	290,987	295,159	1,177,978	0	1,177,978	-7,215	1,170,763
9. Medical Director	0	0	19,250	19,250	0	19,250	0	19,250
10. Nursing & Medical Records	2,222,359	136,394	32,307	2,391,060	0	2,391,060	0	2,391,060
10a. Therapy	0	0	757,583	757,583	0	757,583	0	757,583
11. Activities	163,137	13,142	3,458	179,737	0	179,737	0	179,737
12. Social Services	72,946	0	2,788	75,734	0	75,734	0	75,734
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,458,442	149,536	815,386	3,423,364	0	3,423,364	0	3,423,364
17. Administrative	169,598	0	354,280	523,878	0	523,878	-354,280	169,598
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	52,778	52,778	0	52,778	7,456	60,234
20. Fees, Subscriptions & Promotion	0	0	22,306	22,306	0	22,306	-426	21,880
21. Clerical & General Office	343,367	35,078	21,716	400,161	0	400,161	16,149	416,310
22. Employee Benefits & Payroll	0	0	488,119	488,119	0	488,119	55,091	543,210
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	3,986	3,986	0	3,986	1,988	5,974
25. Other Admin. Staff Trans	0	0	0	0	0	0	6,564	6,564
26. Insurance-Prop.Liab.Malpractice	0	0	134,774	134,774	0	134,774	2,571	137,345
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	512,965	35,078	1,077,959	1,626,002	0	1,626,002	-264,887	1,361,115
29. Total General Administrative	3,563,239	475,601	2,188,504	6,227,344	0	6,227,344	-272,102	5,955,242
30. Depreciation	0	0	46,574	46,574	0	46,574	138,868	185,442
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	6,904	6,904	0	6,904	253,788	260,692
33. Real Estate	0	0	0	0	0	0	74,785	74,785
34. Rent - Facility & Grounds	0	0	853,497	853,497	0	853,497	-853,497	0
35. Rent - Equipment & Vehicles	0	0	3,639	3,639	0	3,639	2,850	6,489
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	910,614	910,614	0	910,614	-383,206	527,408
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	205,469	350	205,819	0	205,819	0	205,819
40. Barber and Beauty Shop	0	0	32,055	32,055	0	32,055	0	32,055
41. Coffee and Gift Shops	0	0	1,114	1,114	0	1,114	0	1,114
42. Provider Participation	0	0	82,125	82,125	0	82,125	0	82,125
43. Other (specify):*	0	0	70,271	70,271	0	70,271	-70,271	0
44. Total Special Cost Ce	0	205,469	185,915	391,384	0	391,384	-70,271	321,113
45. Grand Total	3,563,239	681,070	3,285,033	7,529,342	0	7,529,342	-725,579	6,803,763

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	503,733	506,164
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,562,997	1,562,997
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	42,015	42,015
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	53,347	53,347
9. Other (specify):	0	31,622
10. Total current assets	2,162,092	2,196,145
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	5,628	5,628
13. Land	0	1,289,511
14. Buildings, at Historical Cost	0	4,110,586
15. Leasehold Improvements, Historical Cost	396,381	576,061
16. Equipment, at Historical Cost	153,917	580,022
17. Accumulated Depreciation (book methods)	-158,400	-1,923,776
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	36,443
24. Total Long-Term Assets	397,526	4,674,475
25. Total Assets	2,559,618	6,870,620
CURRENT LIABILITIES		
26. Accounts Payable	360,623	360,623
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	169,640	169,640
31. Accrued Taxes Payable	4,040	4,040
32. Accrued Real Estate Taxes	0	72,600
33. Accrued Interest Payable	0	20,637
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	125,884	72,742
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	660,187	700,282
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	3,668,719
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	3,668,719
46.Total Liabilities	660,187	4,369,001
47.Total Equity	1,899,431	2,501,619
48.Total Liabilities and Equity	2,559,618	6,870,620

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	8,256,508
2. Discounts and Allowances for all Levels	-639,116
Subtotal - Inpatient Care	7,617,392
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,275,373
7. Oxygen	-7
Subtotal - Anciliary Revenue	1,275,366
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	774
13. Barber and Beauty Care	38,126
14. Non-Patient Meals	293
15. Telephone, Television, and Radio	49
16. Rental of Facility Space	0
17. Sale of Drugs	222,637
18. Sale of Supplies to Non-Patients	0
19. Laboratory	11,717
20. Radiologyand X-Ray	6,764
21. Other Medical Services	89,972
22. Laundry	2,323
Subtotal - Other Operating Revenue	372,655
24. Contributions	0
25. Interest and Other Investments Income	255
Subtotal - Non-Operating Revenue	255
27. Other Revenue (specify):	484
28. Other Revenue (specify):	0
Subtotal - Other Revenue	484
30. Total Revenue	9,266,152
31. General Services	1,177,978
32. Health Care	3,423,364
33. General Administration	1,626,002
34. Ownership	910,614
35. Special Cost Centers	309,259
35. Provider Participation Fee	82,125
37. Other	0
40. Total Expenses	7,529,342
41. Income Before Income Taxes	1,736,810
42. Income Taxes	0
43. Net Income or Loss for the Year	1,736,810

Page	
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22	
23	Provider Participation fee is linked from page 4